TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, February 8, 1893.

JOHN A. WYETH, M.D., Vice-President, in the Chair.

THORACOPLASTY BY SUBCUTANEOUS EXCISION OF RIBS.

Dr. F. LANGE presented a girl, seven years of age, upon whom he had operated for an empyema of more than six months' standing. When he first saw the patient, in October, 1892, she was extremely emaciated, due to profuse suppuration. The abscess cavity was so large that a diminution of it through expansion of the shrunken lung could not very well be hoped for. The object of the operation was to make the thoracic wall over the cavity sufficiently movable to allow it to become depressed. The general condition of the patient was so extremely reduced that an operation with great loss of blood was out of the question. It was necessary to remove the posterior convex arch of the ribs from a point near the insertion of the large muscles of the back to the anterior axillary line in front. This would involve the arched portion of the ribs, and yield a considerable amount of depression at the expense of the thoracic cavity.

The operation was performed as follows in the case presented: An incision was made beginning between the scapula and vertebral column at a point corresponding to the third rib, and carried downward as far as required, according to the number of ribs to be removed. Another incision was made in the anterior or axillary line. Between these two incisions each rib, to a limited extent, was stripped of its periosteum and cut across with bone scissors. This movable portion of the rib was then grasped with the bone forceps, and lifted out of its periosteal envelope. Usually the periosteum on the upper edge of the ribs will yield more readily to an instrument working from the vertebral column forward, while that on the lower edge can be more easily removed by an instrument working from the anterior

incision backward. Small, adherent shreds of periosteum can be readily loosened by slightly twisting the rib. The parallel empty cylinders of periosteum are left. By means of the operation the size of the abscess cavity is lessened and the new formation of a resistant thoracic wall is allowed.

In the patient presented, five ribs were removed after the manner described, beginning at the third rib. A small resection of the lower ribs was also done for the purpose of drainage. The operation required two sittings, owing to the extreme weakness of the patient. Since the operation the cavity has rapidly diminished in size, the discharge of pus has become less, and the general condition of the patient is markedly improved. There is still a small cavity left, containing about half an ounce of fluid, but the chances for a complete recovery are very promising. Repeated searches for tubercle bacilli have given a negative result. In an adult the operation is more tedious, on account of the intimate insertions of the muscles of the back.

Dr. JOHN A. WYETH said that in the removal of the ribs he had always found it quite easy to take out the rib from its periosteal attachment and sheath without opening into the pleural cavity.

SARCOMA OF AN UNDESCENDED TESTICLE.

Dr. CHARLES MCBURNEY presented a patient, a young man, who was brought to him the middle of last December suffering from the existence of a somewhat peculiar abdominal tumor of considerable size. The tumor could be readily felt. It extended from the pubes to one inch above the umbilicus, and about four inches to each side of the median line. It was nearly spherical, quite firm to the touch and gave rise to considerable pain. The growth was quite movable. Its appearance had been first noted about a year before. The condition of the patient was somewhat unusual, also. His legs and feet and portions of his thighs were œdematous to a marked degree, with great enlargement of the veins. Throughout the entire extent of the abdominal wall, and of the thoracic wall as well, there was enormous enlargement of the veins, the vessels crossing themselves in every direction.

An operation was undertaken with a view to determine the exact nature of the tumor, a suspicion of which existed from the fact that the testes were not found in their usual situation. The incision, made

in the median line, met with a large amount of venous hæmorrhage, and exposed a reddened, smooth tumor, ovoid in shape, which was found to be practically unattached excepting at one point. During its enucleation it was clearly seen that the growth consisted of an enlarged right testis, and that its pedicle was formed by the cord running in its usual direction. A portion of the epididymis was also recognized. The pedicle was ligated and the tumor removed.

Dr. McBurney said that when he undertook to close the abdominal wound he found the veins to be so numerous and of such large size, and still so distended with blood, that the use of the needle would certainly have been followed by profuse hæmorrhage and considerable loss of time. This difficulty he met by grasping the deeper layers of the abdominal wound on each side with forceps throughout the entire length of the wound; six pairs of forceps were required on each side. Each pair of forceps was then crossed with the corresponding pair on the opposite side, and a ligature tied at the base of the two; in this way the tissues were kept in exact apposition. The superficial portion of the wound was left open and treated by packing. The forceps were left in position for ten days, and when they were removed union was found to be complete. The granulation surface left was subsequently scraped, and the edges of the wound, which were no longer especially vascular, were sutured.

The œdema and vascular changes, Dr. McBurney said, were, of course, due to pressure, but it appeared to him to be somewhat singular that a tumor of this moderate size should produce such a marked effect in every direction, when tumors of much larger size generally do not do so at all. It could only be accounted for by the close fitting of this growth to the brim of the pelvis, thus causing unusually complete occlusion of the iliac veins. The tumor proved to be a round-celled sarcoma of the right testis.

Dr. Lange remarked that since Dr. McBurney had not tried a suture in his case and thereby got dangerous bleeding, he was inclined to assume that in this case, like in others of abdominal tumor with hæmorrhage from dilated veins of the abdominal wall, after removal of the tumor the veins would collapse, and suturing might not have been as dangerous as assumed, especially since the abdominal wall, by pressure previous to the passing of the needle, could be made bloodless.

Dr. McBurney, in reply to Dr. Lange's remarks, said that he had already distinctly explained why sutures were not used. The

patient was in very feeble condition, and the loss of a few more ounces of blood and of additional time might have led to a fatal termination. The tumor had already been removed, and there was no hope that the veins would collapse. The fact was, that they had not collapsed at the time when the abdominal wound required closing.

DR. LANGE rejoined that Dr. McBurney overrated the danger of bleeding. Not unfrequently we cannot avoid large vessels in securing large pedicles and adhesions in intra-abdominal operations. As soon as the suture or ligature is tied the bleeding ceases. We also do not hesitate to press needles through vascular tumors with distinct intentions. He inquired whether in all the layers of the abdominal wall the veins were so much dilated that neither peritonæum nor fascia could be sutured.

If the veins did not collapse, then there was probably some additional compression, perhaps, through metastasis higher up.

DR. MCBURNEY replied that he had not overrated the danger of bleeding in this particular case, which was the only one under discussion. The abnormal vascularity involved all the different layers of the abdominal wall, and the danger was a perfectly evident one. While he was not exceptionally timid in regard to hæmorrhage, he had found it good practice in surgery to avoid, when possible, the passing of a needle and suture through a large vein. If this were done the tightening of the suture would frequently enlarge the opening formed by the needle, and lead to considerable bleeding. It was now two months since the operation was done, and there was still marked dilatation of the vessels of the abdominal wall.

HYPERDISTENTION OF THE PROSTATIC URETHRA FOR RELIEF OF PROSTATIC OBSTRUCTION.

DR. L. BOLTON BANGS read the paper of the evening on the above subject. (See page 442.)

DR. MCBURNEY said that the dilatation of the prostatic urethra in these operations is an interesting question, and one that has been too much neglected. Following supra-pubic operations, he had always had more or less difficulty in draining the bladder, and it had occurred to him whether this difficulty could not be obviated by making the perineal opening, if a sufficiently large opening could be made there with impunity, answer the purpose of the operation. Of late years he has done very little work in the bladder through the

perinæum. Formerly, he often employed the median incision, particularly in young subjects.

DR. WYETH said he thought a good deal of the trouble in connection with drainage after supra-pubic cystotomy came from the lack of close attention to the condition of the drainage apparatus during the first twenty-four hours. The tube often becomes choked up by blood-clots. He has up to the present time employed this method of drainage in thirty cases, and in none of them did any serious difficulty arise. When the tube becomes stopped up, it can be readily cleaned. The air should be excluded from the bladder by packing gauze around the tube. The flow of urine through the tube should be regulated, so as not to exhaust the bladder. Dr. Wyeth said he considered Dr. Bangs' suggestion of hyper-distending the prostatic urethra a very valuable one.